Mental Health Crisis Management Report

SFY 2012-13: Second Quarter Report

Session Law 2012-128 (Section 2)

April 1, 2013

NC Department of Health and Human Services
Division of Mental Health, Developmental Disabilities and Substance Abuse Services

Mental Health, Developmental Disabilities and Substance Abuse Services

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Executive Summary

Session Law 2012-128, Section 2, requires the North Carolina Department of Health and Human Services to study Local Management Entity (LME) efforts and activities to help reduce:

- *the need for acute care inpatient admissions for patients with a primary diagnosis of a mental health, developmental disability or substance abuse disorder, and*
- *the number of patients requiring three or more incidents of crisis services.*

This report lays out the existing array of crisis services in the state, and the efforts by the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (NC DMH/DD/SAS), its partners, and the LMEs to address the two legislative priorities. Baseline data is also presented by LME on inpatient admissions and individuals' repeated usage of crisis services.

As indicated in this report, the NC DMH/DD/SAS and LMEs have made and will continue to make significant efforts to address the high rates of inpatient and crisis services utilization for the persons served in North Carolina's publicly-funded system. It is believed that as LMEs evolve and mature in their role as Managed Care Organizations, as relationships with emergency departments (EDs) and hospital inpatient are established or enhanced, and as non-crisis community-based services are expanded and the quality of those services improved, fewer people will need crisis services and fewer who do need crisis services will be directed to EDs and inpatient services.

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Introduction

Session Law 2012-128, Section 2, requires the North Carolina Department of Health and Human Services (NC DHHS) to study local management entity (LME) efforts and activities to help reduce:

- *the need for acute care inpatient admissions for patients with a primary diagnosis of a mental health, developmental disability or substance abuse disorder, and*
- *the number of patients requiring three or more incidents of crisis services.*

NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (NC DMH/DD/SAS) has produced a reporting template for the LMEs to use to identify their efforts and activities pertinent to the two priorities that are bulleted above. The NC DMH/DD/SAS has also developed a crisis and inpatient database that will be used to track utilization trends by LME.

Three main sections comprise this report. The first section presents an overview of state level efforts and activities intended to address the crisis services issues and the crisis services needs of the public in North Carolina. The second section contains statewide data relative to acute care inpatient admissions and the repeated use of crisis services, enabling the NC DMH/DD/SAS to monitor the impact of state and local efforts to address the two priorities. The third section summarizes the LMEs' current and ongoing efforts and activities pertinent to the two legislative priorities of Session Law 2012-128, Section 2, with the individual LME quarterly reports (October – December 2012) appended to this report.

Section One: State-level Efforts and Activities

Overview of the Community-based Crisis Services Continuum in North Carolina

The North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (NC DMH/DD/SAS), the North Carolina Division of Medical Assistance (NC DMA), and the Local Management Entities (LMEs) in the state have established an array of crisis services resources to address the crisis services needs of people living in the state. These resources are intended to reduce the need for emergency departments (ED) admissions and acute care inpatient hospitalization for people with mental health, developmental disabilities, and/or substance abuse disorders, who experience emergent and urgent crises.

Community-based Non-Hospital Services:

- twelve LME Call Centers
  Provides 24-hour telephonic crisis response and referral.

- 48 Mobile Crisis Management (MCM) teams
  Mobile, primarily face-to-face crisis assessment and response, with linkage to services/supports.

- 26 Facility Based Crisis (FBC) programs
  Alternative to hospitalization for adults who need brief, intensive, 24-hour crisis evaluation and treatment beds; eight of these are designated to treat involuntarily admitted individuals.

- 16 Non-Hospital Medical Detox agencies
  Medically Monitored Detoxification delivered by medical and nursing professionals in 24-hour facility that provides medically supervised evaluation and withdrawal management services.

- six Social Setting Detox agencies
  Clinically Managed Residential Detoxification delivered under clinical supervision of board-certified/licensed substance abuse professional in 24-hour facilities; characterized by peer and social support.

- 78 Walk-In Crisis and Immediate Psychiatric Aftercare clinics (WICs)
  Serves adults, adolescents, and families who are in crisis or who need interim services following discharge from out-of-home services and prior to admission to routine services; primarily available during regular business hours; linkage to other services/supports.

- six NC START (Systematic, Therapeutic, Assessment, Respite and Treatment) teams, and twelve Crisis Respite beds.

In-home crisis response and crisis respite for individuals who have intellectual/developmental disabilities and who are in crisis; providing ongoing training, consultation, and support to family members and providers.

- Crisis Intervention Team (CIT) trained officers in each LME catchment area; 3925 CIT officers in NC (18% of total law enforcement officers, from 280 participating law enforcement agencies)
  Pre-booking jail diversion program; law enforcement officers trained to de-escalate crises and assist individuals to access needed services rather than proceed to automatic incarceration.

Through the Integrated Payment and Reporting System (IPRS) and appropriations from the North Carolina General Assembly, the North Carolina Department of Health and Human Services has provided access to inpatient hospital beds for indigent persons needing inpatient care.

Community-based Psychiatric Inpatient Services:

- 2,022 total psychiatric inpatient beds, excluding State Hospitals
  This total includes three-way contract psychiatric inpatient beds (see below) as well as all other community-based psychiatric inpatient beds.

- Of the 2,022 total beds,135 are three-way contract psychiatric inpatient beds
  Inpatient service targeted specifically for individuals who are indigent. NC DMH/DD/SAS, LMEs, and 22 hospitals have contracted to provide this inpatient service.

The North Carolina Division of State Operated Healthcare Facilities (NC DSOHF) administers three state psychiatric inpatient hospitals and three Alcohol and Drug Abuse Treatment Centers (ADATCs) that serve as the safety net in the continuum of crisis services.

State Operated Services in Crisis Services Continuum:

- 850 State Psychiatric Hospital beds in three state hospitals
  Provide crisis assessment, stabilization, and medical care in inpatient facilities; discharge planning to facilitate linkage to the community services and supports.

- 240 ADATC beds
  There are three ADATCs; each facility has 80 beds. The ADATCs are certified by the Centers for Medicare and Medicaid Services as

psychiatric hospitals. They provide an array of services including medical detoxification and psychiatric stabilization in addition to inpatient substance abuse treatment.

There are also 120 EDs in North Carolina, which are often used by people when they experience behavioral health emergencies. Many hospital EDs have developed specialized areas to care for behavioral health patients requiring extended stays due to lack of inpatient capacity.

Emergency Department Length of Stay Action Plan

In November 2011, the NC DMH/DD/SAS published a set of recommendations (http://www.ncdhhs.gov/mhddsas/services/crisisservices/edlengthofstayplan.pdf) in the Emergency Department Length of Stay Action Plan that were developed by a large group of stakeholders and were intended to:

- reduce admissions of persons with mental health, developmental disabilities and/or substance abuse (MH/DD/SA) disorders to EDs;
- reduce the length of stay (also known as wait times or psychiatric boarding) for individuals with behavioral health issues in EDs; and
- link those persons to services, supports, and housing resources to avoid readmissions to EDs.

A total of 25 recommendations were made, which were organized according to and targeted at four timeframes related to an emergent crisis episode: pre-crisis, pre-admission to an ED, during an ED admission; and post-discharge from an ED. If implemented successfully, these recommendations would be expected to result in reduced admissions and re-admissions to EDs and shortening lengths of stay in the EDs, as well as reduced community inpatient hospital admissions.

For the reader's convenience, the 25 recommendations are re-presented here:

Before a Crisis Occurs:

1. Develop and provide crisis prevention/de-escalation training;
2. Require enhanced crisis reduction plans for high risk, high volume consumers;
3. Increase provider accountability for consumer outcomes;
4. Convene critical care conferences for individuals who have high utilization of crisis services;
5. Develop funding and planning to provide transportation;

During a Crisis, But Before Admission to the ED:

6. Enhance the effectiveness and efficiency of MCM services;
7. Augment the role of FBC centers and 24-hour WIC;
8. Work with law enforcement;
9. Enhance accountability of first responders;
10. Develop consistent Screening, Triage, and Referral procedures;
11. Use non-ED resources for medical clearance evaluations;
12. Work with magistrates;
13. Provide care coordination;
14. Diversify and strengthen the workforce;

At the ED:

15. Implement a computerized psychiatry bed registry;
16. Develop protocols and practice guidelines to standardize/utilize best practices for services in the EDs;
17. Clarify and support the role of LMEs with regard to ED behavioral health crisis admissions;
18. Reduce legal obstacles;
19. Enhance disposition options for individuals with behavioral health crises in the ED.;
20. Engage individuals with substance use disorders earlier and link to treatment services;

After Discharge from the ED:

21. Ensure available housing and essential benefits are available in order to help the person remain successfully in the community and out of EDs;
22. Develop of uniform system of care coordination;
23. Implement Assertive Engagement statewide;
24. Prior to discharge from EDs, schedule follow-up appointments within 48 hours; &
25. Establish local relationships among all stakeholders to facilitate seamless coordination of care.

The ED Length of Stay Action Plan was intended in part to provide guidance to the LMEs to assist in addressing the burgeoning problem with excessive ED admissions and extraordinarily lengthy wait times for persons needing psychiatric inpatient beds. The current LME Quarterly Reports, described in the second section of this report, reflect efforts and activities, many of which are in concert with or extensions of the Action Plan recommendations.

Efforts to Implement the ED Length of Stay Action Plan

The NC DMH/DD/SAS, in collaboration with several partners, has endeavored to implement a number of the recommendations of the ED Length of Stay Action Plan:

- Working with NC DMA, NC DMH/DD/SAS has revised the service definition of FBC programs (see recommendation #7 on page 6), which serves adults, so as to strengthen and increase the involvement of licensed professionals and the quality of clinical services, to increase 24/7 access to the service, and ensure that all of these facilities are capable of admitting and treating persons who are under involuntary commitment. The revised service definition awaits rate-setting and approval from NC DMA. This service definition revision is aimed at enhancing this service so that it will be a viable alternative to psychiatric inpatient hospitalization.

- NC DMH/DD/SAS and NC DMA have also developed a new service definition, FBC for children and adolescents (see recommendation #7 on page 6). This service definition has already been approved by the Centers for Medicare and Medicaid (CMS), and awaits state-level financial resources needed to fund the service. Similar to the revised FBC service for adults, this service is intended to provide a high quality alternative to inpatient hospitalization.

- NC DMH/DD/SAS has worked with multiple stakeholders, including LMEs and NC DMA, to revise the elements of the individualized Crisis Plan (see recommendation #2 on page 5), which is component of the Person Centered Plan. The revised Crisis Plan is more robust than the previous Crisis Plan, with the addition of such essential information as diagnoses, current medications, medical concerns, contact information of the individuals who provide important support to the consumer, as well as a planning section for following-up with the consumer after the crisis has been resolved. The Crisis Plan is designed to be used primarily to prevent the escalation or worsening of a crisis episode, allowing the resolution of a crisis before the need for an ED admission and/or psychiatric inpatient treatment. It is intended to be implemented by the end of February 2013.

- NC DMH/DD/SAS, with NC DHHS leadership and involvement of East Carolina University, the University of North Carolina at Chapel Hill, the Albemarle Hospital Foundation, and the North Carolina Hospital Association, has been pursuing the development of an expanded telepsychiatry consultation initiative in EDs (see recommendation #19 page 6). This initiative is in the planning stages, and like the very successful model in South Carolina, is intended to shorten length of

stays in the ED and assist in guiding ED physicians in making disposition decisions, when appropriate, to less costly and less restrictive services than psychiatric inpatient hospitalization.

- NC DSOHF has developed plans to add 124 beds at Cherry Hospital after its new facility opens in the Spring of 2013, and an additional 19 beds at Broughton Hospital, which are pending approval by the North Carolina Office of Budget and Management (see recommendation #19 on page 6). This anticipated increase in state hospital beds will help to reduce lengths of stay in EDs for individuals waiting for a state hospital bed to become available.

- NC DMH/DD/SAS has inserted draft language into its 2014 contract with the LME-Managed Care Organizations (LME-MCOs) with respect to strengthening care coordination activities for persons who seek crisis services (see recommendation #13 on page 6). The draft contract specifies the broad priority populations for which care coordination activities shall be required, including children and adults with intellectual and development disabilities, mental health, or substance dependent disorders, and persons who have a combination of the former disorders. In addition, the contract would require the LME-MCOs to provide care coordination for persons who are at risk for crisis, including those who miss scheduled appointments and who are at risk for inpatient or emergency treatment, or who use a crisis service as the first service, or who are discharged from inpatient psychiatric hospitalization, a Psychiatric Residential Treatment Facility, or FBC service. Care coordination activities would include linking the individuals to appropriate services, ensuring that they continue to be engaged with needed treatment and supports, monitoring hospital admissions, developing crisis plans for those individuals, and discharge planning to appropriate dispositions and coordinating access to follow-up services and supports.

- NC DMH/DD/SAS collaborated with the North Carolina chapter of the National Alliance for Mental Illness (NC NAMI) and several law enforcement agencies, to revise the Basic Law Enforcement Training for law enforcement officer candidates and developed an inservice training for current law enforcement officers (see recommendation #8 on page 6); both of which are mandated trainings and teach de-escalation techniques and encourage the law enforcement officer to utilize alternative crisis services, rather than unnecessarily transporting all persons with behavioral health crises to EDs.

- NC DMH/DD/SAS has developed a protocol for the MCM team's role in the EDs, which would require the teams' licensed professionals and the psychiatrists to

take an active role in providing consultation to the ED physicians regarding disposition (i.e., whether the individual requires inpatient hospitalization or referral to a less restrictive service in the community (see recommendation #6 on page 6). This protocol could be inserted into the MCM service definition in a future revision.

- In March 2012, at the request of NC DMH/DD/SAS Medical Director, LMEs identified LME points of contact for local EDs, and enlisted the NC Hospital Association to distribute that contract list to all EDs (see recommendation #17 on page 6). This is intended to encourage increased collaboration between EDs and LMEs in order to facilitate appropriate dispositions of persons following discharge from the ED.

- In calendar year 2012, with funding appropriated by the NC General Assembly, NC DMH/DD/SAS increased the number of three-way beds inpatient hospital beds available in community hospitals from 121 to 135 and extended a contract to one additional hospital (see recommendation #19 on page 6).

- In SFY 2013, NC DMH/DD/SAS requested and received expansion funding for additional three-way beds (see recommendation #19 on page 6). The NC General Assembly approved a nine million dollar increase for three-way beds, but the funds are being held by the State Budget Director until it is determined whether or not the money will be needed to off-set a Medicaid shortfall.

- In SFY 2013, NC DMH/DD/SAS hired a Housing Administrator who provides state-level guidance to the LME Housing Coordinators (see recommendation #21 on page 6). These positions all focus on helping homeless people, who receive or need mental health, developmental disabilities, or substance abuse services, to access desperately needed housing stock. The lack of housing has been identified as one major factor in driving high admission rates in EDs

- LMEs are required, by the current contract with the NC MH/DD/SAS, to hire housing coordinators to increase access to housing and support services for the people receiving MH/DD/SA services (see recommendation #21 on page 6).

Section Two: Statewide Data on Psychiatric Inpatient Admissions and the Number of Persons Needing Three or More Crisis Services within a Twelve Month Period

Overview of the Data

To assess the impact of the efforts and activities to reduce acute psychiatric inpatient admissions and the number of individuals having repeated crisis episodes, NC DMH/DD/SAS is tracking admissions of people with primary mental health, developmental disabilities, and/or substance abuse diagnoses to community and state inpatient hospitals and the number of persons who have received crisis services three or more times within a year. The data was derived from claims for services paid by Medicaid as well as state-funded services, paid through the IPRS, and are presented by LME.

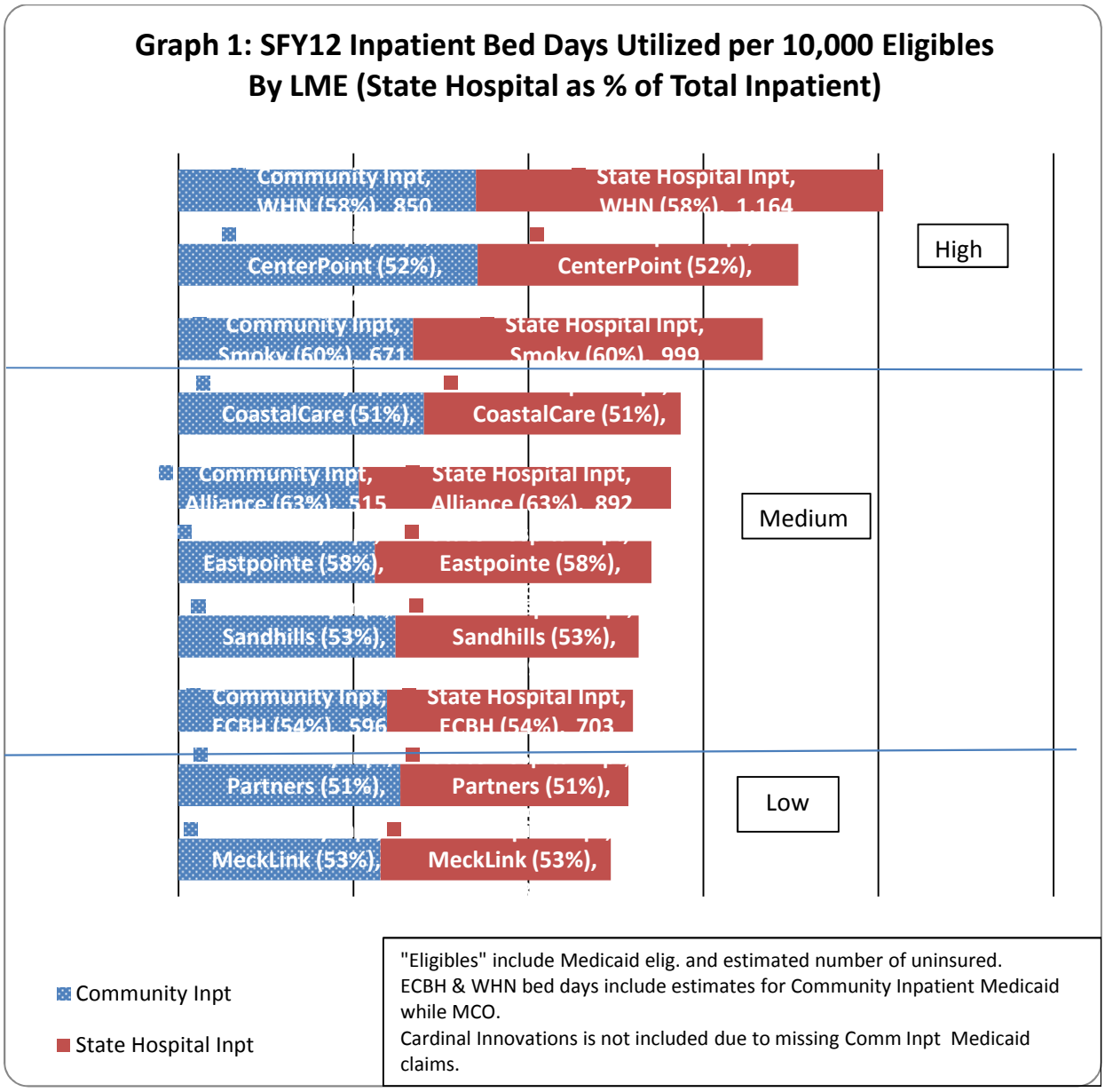
The following graphs display baseline data for SFY 2012. NC DMH/DD/SAS will use this data as a starting point for determining areas in need of further study to improve our understanding of what services, activities and initiatives are effective in reducing the number of consumers experiencing repeated crises and psychiatric decompensation resulting in hospitalization.

The data shows a wide variation in rates of psychiatric inpatient utilization and persons with repeated crisis events across LMEs. However, it is too early to draw conclusions that the LMEs with the higher rates are less effective, or that those with lower rates are more effective.

It is likely that the variation is due in part to incomplete information, since the data does not include ED visits for non-Medicaid consumers, evaluations at walk-in crisis centers, or services reimbursed with other sources, such as county funds. Availability of walk-in crisis centers and county funded services varies considerably across the state. Another factor to take into consideration is that the graphs on the next page, reflect the new LME catchment areas, which for many LMEs differs from how they were configured during SFY 2012. There can be considerable variation in service utilization patterns and service capacity within the current LME configurations, between counties and legacy LME catchment areas. An LME may, on average, have a utilization rate in the mid-range, while in fact some counties have low utilization and others are quite high.

Results

Graph 1 depicts the inpatient psychiatric utilization by LME for SFY 12, inclusive of both community and State Hospital psychiatric inpatient.



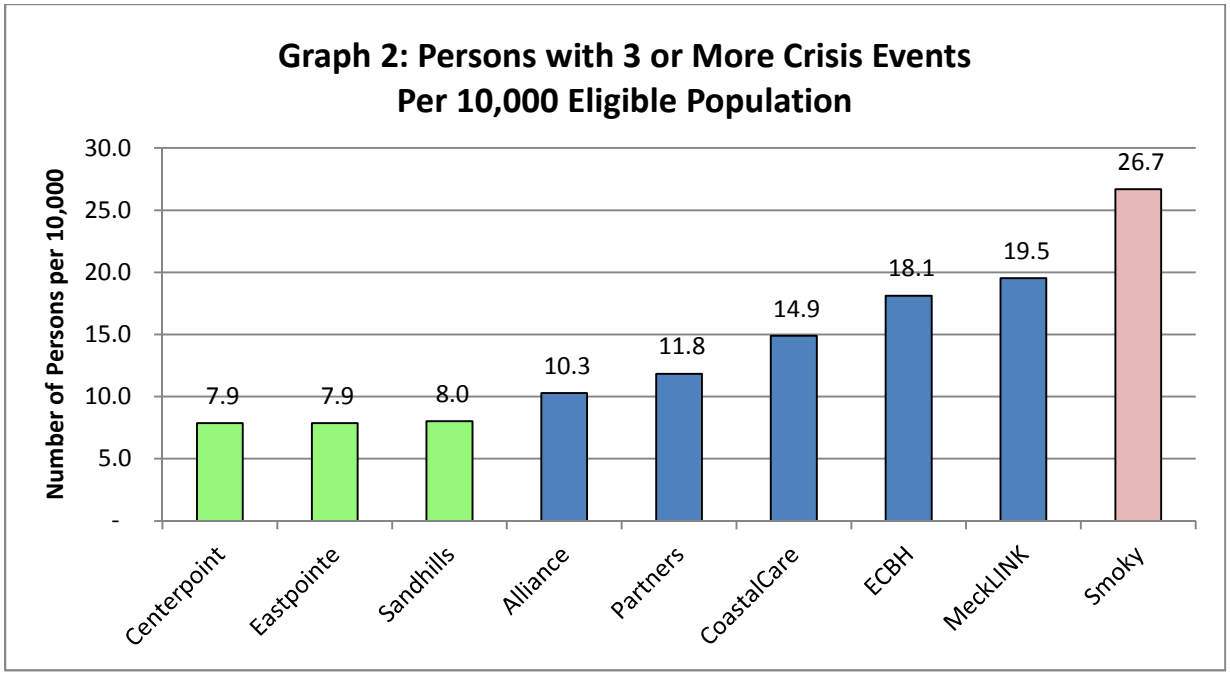
Eligible Population is estimated based on the number of persons with Medicaid eligibility, and an estimated number of uninsured persons in the catchment area of each LME. This number is the best available estimate of persons who fall within the purview of the public mental health system. Cardinal Innovations is not included in the graph due to incomplete Medicaid encounter claim data (LMEs that have implemented the Medicaid Waiver are working with DHHS to solve incompatibility issues that have prevented encounter claim submission/acceptance).

Graph 1 depicts bed day utilization rates, which combines admission and length of stay data to give a fuller picture of inpatient resource consumption. [1] Bed day utilization of

[1] Community inpatient admission rates vary from a high of 135 admits per 10,000 eligible population to a low of 57 admits per 10,000 eligible population, with an average of 76. The average length of stay per LME for these admissions also varies significantly, from 6.1 to 10 days. Therefore, although 57 admit rate seems low, this low admission rate coincides with longest length of stay among the LMEs, resulting in an overall utilization of community inpatient beds based on bed days that is in the mid-range.

psychiatric inpatient resources varies significantly across the LMEs. The LMEs with "high" inpatient rates utilize 44% more bed days than the "low" group of LMEs, on average. As stated previously, however, these rates may not reflect the entire picture. MeckLINK's and Alliance's utilization rate may be affected by County funded community inpatient beds that are not reflected in this data. Additionally, the variation in rates of utilization of State Hospital psychiatric inpatient are likely influenced by proximity to the State Hospitals (accessibility) and urban drift of persons with mental disorders.

Graph 2 shows the rate of persons with repeated use of crisis services by LME for dates of service during the SFY 12.



Included in this graph are Medicaid and State funded Mobile Crisis Management, Facility Based Crisis, and Detox services; also included are Medicaid ED visits – data is not available on ED usage by State-funded consumers. Eligible Population is estimated based on the number of persons with Medicaid eligibility, and an estimated number of uninsured persons in the catchment area of each LME. Western Highlands and Cardinal Innovations are not included in the graph due to incomplete Medicaid encounter claim data (these LMEs have implemented the Medicaid Waiver and are working with DHHS to solve IT problems that have prevented encounter claim submission).

The LMEs at the higher end of the scale have over twice the rate of persons with three or more crisis visits as those at the lower end. The high rate at Smoky Mountain Center was primarily due to the MCM services provided by one large provider that is no longer in business, so Smoky Mountain Center's rate is expected to decrease in future reports. Even so, the differences in rates across LMEs are worth further study. An unknown factor is the utilization of Walk-In Crisis centers for assessment and triage of persons in crisis. Currently, claims data does not allow for identification of crisis events at these centers, and so the numbers of persons whose crises were treated at these centers is not included in the data. In the future (calendar year 2013), psychotherapy for crises

(emergent) will be identifiable by a new CPT billing code, regardless of the location, which will allow for more comprehensive data and analysis of the crisis events.

Section Three: Summary of Efforts and Activities by LMEs

In their quarterly reports, the LMEs identified numerous efforts and activities that are intended to address one or both of the priorities of Session Law 2012 – 128, Section 2. The LMEs' efforts and activities fall into nine categories, most of which coincide with recommendations from the ED Length of Stay Action Plan, described above. No LME addressed all nine categories, but some of the activities reported by the LMEs could fall into more than one category:

1. Care Coordination/Care Management
2. Collaboration
3. Training
4. Individualized Prevention & Treatment Planning
5. Community-based Crisis Services
6. First Responders
7. Community-based MH/DD/SA Non-Crisis Services and Supports
8. Quality Improvement (data mining, etc.)
9. Housing and the Homeless

1. Care Coordination/Care Management

   The ED Length of Stay Action Plan included two care coordination recommendations: one would divert persons in crisis to non-hospital based care (i.e., avoiding the ED and inpatient hospitalization) by linking the individuals to appropriate crisis services alternatives (e.g. MCM, FBC), and to follow-up non-crisis care in the communities; the other would assist with discharge planning from EDs, guide discharged individuals into non-hospital community-based services, and follow-up with individuals who miss their post-ED appointments with community-based providers.

   All LMEs included one or more care coordination activity in their quarterly reports, which is aimed at reducing inpatient admissions and/or repeated crisis services usage. Some of the activities would likely address both priorities.

   Examples of LME efforts on collaboration with partners that are targeted at reducing inpatient admissions and/or readmissions include, but are not limited to:

- locating care coordinators in EDs to assist with and expedite appropriate dispositions, which would also reduce psychiatric boarding (i.e., wait times in the EDs);
- linking individuals in EDs and in inpatient psychiatric hospital beds to follow-up medication management appointments and other community-based behavioral health services and supports; and
- intensive follow-up for individuals discharged from state hospital beds.

Examples of LME care coordination efforts that are intended to reduce the need for repeated use of crisis services include, but are not limited to:

- identifying and coordinating care for persons who have had 2 or more crisis services in a twelve-month period; and
- identifying persons who are Medicaid-eligible and indigent, and who are at high risk for repeated crisis events or who evidence a high need for intensive services in order to develop or enhance the person centered plans, including crisis plans.

2. Collaboration

The ED Length of Stay Action Plan included recommendations to work with law enforcement and magistrates to promote the use of non-hospital based crisis services (e.g., MCM, FBC) as alternatives to EDs. Another recommendation focused on using non-ED medical facilities (e.g., urgent care centers) to conduct medical clearance for persons seeking admission to FBC programs. Eleven of the twelve LMEs listed one or more activities that clearly fall into the category of collaboration.

Examples of LME efforts on collaboration with partners that are targeted at reducing inpatient admissions and/or readmissions include, but are not limited to:

- accessing Community Care of North Carolina's (CCNC) Alert System to notify care coordinators when a Medicaid-eligible person is admitted to EDs – the care coordinators could then work to divert the individual from subsequent inpatient care to non-hospital based services/supports;
- working with ED physicians to identify and seek out appropriate non-hospital based alternatives to inpatient care, such as FBC, and other community-based services/supports;
- working with hospital inpatient facilities to identify and seek out appropriate discharge options to community-based services/supports; and

- establishing community protocols with law enforcement officers, magistrates, hospitals, and primary care providers on how to help individuals with behavioral health needs (i.e., crisis services or routine care) access appropriate non-hospital based care.

Examples of LME collaboration or communication efforts that are intended to reduce the need for repeated use of crisis services include, but are not limited to:

- LME Medical Directors working with provider Medical Directors on improving quality of care, including the reduction of the need for repeated crisis services; and
- care coordinators working closely with CCNC and the provider-clinical homes to ensure consumers receive both medical and behavioral health care needed to maintain and improve recovery.

3. Training

The ED Length of Stay Action Plan included a variety of recommendations on training in the following areas: crisis prevention and de-escalation training; provision of FBC service; Crisis Intervention Team (CIT) for law enforcement officers and dispatchers; protocols and procedures training for Screen-Triage-Referral personnel; writing high quality crisis plans; competency-based training for crisis responders; mental health, intellectual/developmental disabilities, and substance abuse training to ED personnel; Emergency Medical Treatment and Active Labor Act (EMTALA) and outpatient commitment training for ED physicians. Nine LMEs mentioned training as part of their efforts in one or more areas on their LME Quarterly Reports.

Examples of LME training efforts that are targeted at reducing inpatient admissions and/or readmissions include, but are not limited to:

- expansion of CIT training modules;
- increasing the number of CIT trainings to law enforcement;
- educating/training the community on the mental illness, substance abuse, and intellectual/disabilities, and the services available to meet the needs of the community;
- cross-training to CCNC and primary care providers on behavioral health conditions; and
- implementing the Training Library of modules focusing on health promotion, prevention and early intervention, available to community partners.

Examples of LME training efforts that are intended to reduce the need for repeated use of crisis services include, but are not limited to:

- the use of Care Management Technology system to predict crisis services usage; and
- the Assertive Community Treatment (ACT) training to fidelity of the model;

4. Individualized Prevention & Treatment Planning

The ED Length of Stay Action Plan calls for LMEs to require providers to develop and use crisis plan for high risk, high cost consumers, and to convene critical case conferences for individuals with high utilization of crisis services. Both recommendations are intended to prevent or reduce the occurrence of future crises, to ensure that if the individual does experience a crisis that the most appropriate crisis response service is selected, and that the individual is engaged in effective community based services. Six LMEs included activities that fall into the category of individualized prevention and treatment planning in their LME Quarterly Reports.

Examples of individualized prevention and treatment planning efforts listed in the LME quarterly reports that are targeted at reducing inpatient admissions and/or readmissions include, but are not limited to:

- creating detailed crisis plans;
- MCM collaborating with magistrates, law enforcement, & hospitals to implement crisis plans; and
- ensuring provider compliance with developing and using crisis plans.

Examples of individualized prevention and treatment planning efforts that are intended to reduce the need for repeated use of crisis services include, but are not limited to:

- care coordinators updating high risk/high cost crisis plans;
- communicating expectations to Providers regarding Person Centered Plan development including well-developed crisis plans;
- reviewing and assisting to formulate appropriate crisis plans for high risk and high cost consumers; and
- interdisciplinary teams convening critical case conferences.

5. Community-based Crisis Services

The ED Length of Stay Action Plan calls for enhancing the MCM services, augmenting FBC Services and increasing accessibility to WICs. The recommendations urge that MCM be provided as close to home as possible, rather than in the EDs where it is more likely that a person would end up in inpatient services. It is also recommended that MCM licensed professionals provide crisis assessment and treatment, instead of unlicensed team members, and that psychiatrists are actively engaged in the crisis response effort. This is particularly essential when the service is provided in EDs, wherein ED physicians, who have to decide on the need for inpatient services, can rely on the clinical expertise and judgment of licensed behavioral health professionals.

Additionally, the Action Plan advocated for modifying the FBC service definition for adults so that the service would be able to admit people, including persons with intellectual/developmental disabilities, 24 hours per day, and all FBCs would have the capability to care for individuals who are petitioned for involuntary commitment. Beside the FBC service for adults, the Action Plan recommended a similar service be provided for children.

The Action Plan specifically proposes that WICs expand the hours of operation to allow for greater local access to crisis response services for persons experiencing crises. NC DMH/DD/SAS analyzes data on the use of EDs by persons with MH/DD/SA diagnoses on a quarterly basis. This data shows that:

- Approximately 3.5% of all ED Admissions are persons with a primary Mental Health, Developmental Disability, or Substance Abuse diagnosis (160,000 out of 4.5 million ED admissions annually). Thirteen and one half percent (13.5%, 610,000 admissions) have a primary or co-occurring MH/DD/SA diagnosis.
- From FY10 to FY12, there was an 11.4% increase in the number of ED Admissions for persons with a MH/DD/SA diagnosis, relative to an overall increase in ED utilization of 5.1% for the same period and a 2.9% increase in population. This equates to an increase of 16,000 ED admissions for persons with a primary MH/DD/SA diagnosis.

LMEs varied in the utilization rate of hospital EDs by persons with primary MH/DD/SA diagnoses, with the highest utilization rate being more than twice those at the lower end of the scale. Accessibility to a WIC that is open 24/7 appears to be a factor for those LME regions with the lowest ED usage.

It is important to note that NC DMH/DD/SAS and LMEs support the use of non-hospital based crisis services when the individual's intensity of need and the extent of dangerousness of that person can be safely and effectively addressed by those services. However, when the intensity of need and the level of restrictiveness necessary to address a person's crisis and dangerousness are beyond the capacity of non-hospital based crisis services, ED usage and inpatient hospitalization are appropriate. In their quarterly reports, all twelve LMEs indicate that they will engage in activities to promote the use of alternative (non-hospital based) crisis services.

Examples of non-hospital based crisis service efforts in the LME quarterly reports that are targeted at reducing inpatient admissions and/or readmissions include, but are not limited to:

- collaboration with local law enforcement and magistrates to encourage use of MCM team rather than Involuntarily Commitment;
- creation of 24 hour crisis response centers (WICs) in close proximity to EDs to divert people in crisis from being admitted to EDs; and
- determine feasibility of developing a local FBC for ED diversion and provision of non-hospital based inpatient care in a community setting.

Examples of individualized prevention and treatment planning efforts that are intended to reduce the need for repeated use of crisis services include, but are not limited to:

- assessing the need for additional WIC;
- MCM teams to collaborate in four counties to improve response time;
- increasing use of MCM services by EDs;
- strengthening Walk In Centers and MCM teams through technical assistance and performance management;
- increasing availability of WIC hours to extend them to 8pm; and
- continuing to invest resources in FBCs and WICs.

6. First Responders

The ED Length of Stay Action Plan urges LMEs to require a robust first response by Critical Access Behavioral Health Agencies (CABHAs) and residential providers to individuals in crisis who are served by those organizations. Moreover, the Action Plan suggests that LMEs insist on improved provider accountability and compliance with first responder requirements.

The NC DMH/DD/SAS and NC DMA Implementation Update # 86 (dated April 6, 2011) set out the policy for certain providers regarding first responder responsibilities (p. 4). http://www.ncdhhs.gov/mhddsas/ImplementationUpdates/update086/iu86_april2011_final.pdf, CABHAs shall serve as first responder when any consumer who has been assessed by the CABHA and is receiving services from the CABHA undergoes a crisis. All CABHAs shall have written policies and procedures in place that will be made available to all consumers, and shall include contact information for the consumer to first contact the CABHA rather than other crisis responders, such as hospital emergency departments and mobile crisis management teams. Seven of the LME Quarterly reports included actions to take related to first responder activities by their providers.

Examples of first responder efforts in the LME quarterly reports that are targeted at reducing inpatient admissions and/or readmissions include, but are not limited to:

- monitoring provider compliance with first responder requirements;

- providing technical assistance to providers identified on first responder requirements; and
- if necessary, sanctioning providers that fail to fulfill first responder responsibilities.

Examples of first responder efforts that are intended to reduce the need for repeated use of crisis services include, but are not limited to:

- increasing utilization of first responder activities; and
- aggregating results of First Responder assessment posted on LME's website; provide technical assistance when needed, and require plans of correction if necessary.

7. Community-based MH/DD/SA Non-Crisis Services and Supports

Though the ED Length of Stay Action Plan does not specifically call for enhancing, expanding, or improving the array of non-crisis, community based services, having a strong continuum of non-crisis, community based services are inextricably linked to several recommendations in the Action Plan. The pre-crisis and post-ED recommendations depend heavily upon linking individuals to a robust array of community services.

All LMEs described care coordination efforts to ensure that individuals at risk of crises or after crises had been stabilized are linked to non-crisis, community based services. Moreover, ten of the twelve LME quarterly reports listed specific activities that focused on the non-crisis, community based service continuum.

Examples of non-crisis, community based services efforts in the LME quarterly reports that are targeted at reducing inpatient admissions and/or readmissions include, but are not limited to:

- follow-up for hospital discharges into outpatient;
- expediting authorization for post-ED discharges into community based services; and
- increasing community awareness of Mental Health, Intellectual/ Developmental Disability and Substance Abuse.

Examples of non-crisis, community based services efforts that are intended to reduce the need for repeated use of crisis services include, but are not limited to:

- implementing state-wide initiative to expand evidence-based, high-fidelity ACT Team services in collaboration with NC ACT Coalition & Duke University;
- completing Geo ACCESS survey to determine availability of Community Based Services at all levels of intensity of service need; work with providers in the network to ensure that there is a continuum of care and that services are easily accessible/available for routine services; and
- addressing barriers to accessing services during clinical screenings.

8. Quality Improvement

The ED Length of Stay Action Plan includes a variety of suggestions related to quality improvement and conducting studies on crisis and non-crisis, community based services. Topics to study included the need for and the economic impacts involved in increasing the number of Facility Based Crisis programs and the hours of Walk-In Crisis centers, the need for additional psychiatric inpatient beds, the cost effectiveness of developing a transportation system of individuals without ready access to services, and the impact of the use of Assertive Engagement on ED admissions/readmissions. All twelve LMEs targeted quality improvement efforts to assist in reducing psychiatric inpatient stays and the number of people needing three or more crisis services in a twelve-month period.

Examples of quality improvement activities in the LME quarterly reports that are targeted at reducing inpatient admissions and/or readmissions include, but are not limited to:

- LME Medical Director collaborates with Medical Directors of providers regarding quality of care;
- mine data to determine the number of ED admissions associated with current providers, provide technical assistance to providers identified on first responder requirements and MCM; if necessary, sanction providers that fail to fulfill first responder responsibilities; and
- creating a data tracking system to measure outcomes in prevention, early intervention and crisis management.

Examples of quality improvement activities that are intended to reduce the need for repeated use of crisis services include, but are not limited to:

- utilizing Care Management Technologies (CMT), a predictive modeling technology system, to assist in predicting crisis engagement based on patterns and trends in data specific to quality of care indicators;
- using CMT Quality Indicators for Medication Adherence with antipsychotics, care coordinators will follow the established workflow and scripts to address barriers and educate individuals served and/or providers; and
- assessing LME Customer Services procedures for first responder initiation prior to MCM and identify barriers.

9. Housing and the Homeless

The ED Length of Stay Action Plan identified the need for permanent and stable housing as one key factor that can keep people out of the EDs. In the LMEs' Quarterly Reports, one LME identified activities regarding housing and the homeless.

Examples of efforts to address the homeless and housing needs in the LME quarterly reports that are targeted at reducing inpatient admissions and/or readmissions include, but are not limited to:

- partner with the "Hard to House" sub-committee of the local city/county homeless initiative advisory committee; and
- LME has contracted with Homeward Bound to develop a permanent supported housing program targeting uninsured individuals with no income and who are at high risk of hospitalization.

Examples of efforts to address the homeless and housing needs that are intended to reduce the need for repeated use of crisis services include, but are not limited to:

- improve reporting and tracking of homeless individuals; and
- by embedding a behavioral health professional and a housing specialist in health clinics most frequented by the target population, the system would move toward proactive management of this population. Part of the intake process would include an assessment by the "care manager" for community connections including housing.

Conclusion

Crisis and inpatient services are an essential part of the behavioral health continuum of services, so even the most effective service system will include some level of utilization of these intensive services. The objective is not to eliminate, but to "right-size" the utilization of these services. More study will be needed to determine if regions with very high utilization of these services have issues with the capacity, quality or robustness of the array of community services. That being said, all LMEs indicated that there are efforts underway to improve access to community based services, both alternative crisis services and non-crisis services.

A review of penetration rates and funds spent on key community services (such as ACT and Substance Abuse Intensive Outpatient Program) felt to be key in the prevention of crisis and the maintenance of stability in the community, showed little relationship with hospital utilization rates or rates of persons with three or more crisis events. There are several possible explanations:

- it is unknown how many of the people receiving inpatient and three or more crisis events are the same people receiving routine services from the LME provider network;
- services that are reimbursed with funding other than State or Medicaid funds (primarily county funding) are not captured in available databases;
- walk-in crisis center services are not captured currently as they are not distinguishable from non-crisis services; and
- there may be significant variation in the way in which services are implemented between different areas of the State or between providers, or lack of fidelity to the service definitions, "muddying the waters" and making relationships difficult to ascertain.

The data presented in this report will be used as a baseline, from which comparisons will be made in subsequent quarterly reports to ascertain the impacts of the efforts being made to reduce unnecessary inpatient hospitalization and to reduce the number of individuals in our system who have repeated crisis events.

For future reports, additional analyses will be conducted:

1. A comparison will be done to determine if those utilizing the most crisis and inpatient services are receiving LME funded services.

2. DMH/DD/SAS can engage the LMEs in a discussion of the feasibility of reporting county-funded services through the IPRS system.
3. The new service Psychotherapy for Crisis will be included as it becomes available through the claims system.
4. DMH/DD/SAS will follow-up with LMEs that appear to be outliers with specific crises services and/or inpatient bed day utilization.

As indicated in this report, the NC DMH/DD/SAS and LMEs have made and will continue to make significant efforts to address the high rates of inpatient and crisis services utilization for the persons served in North Carolina's publicly-funded system. It is believed that as LMEs evolve and mature in their role as Managed Care Organizations, as relationships with EDs and hospital inpatient are established or enhanced, and as non-crisis community-based services are expanded and the quality of those services improved, fewer people will need crisis services and fewer who do need crisis services will be directed to EDs and inpatient services.

Reference

Emergency Department Length of Stay Action Plan. Raleigh, NC: North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services.: North Carolina Department of Health and Human Services. November 2011 [Online]. Available at: http://www.ncdhhs.gov/mhddsas/services/crisisservices/edlengthofstayplan.pdf

Appendix A

Abbreviated descriptions of the efforts and activities of each LME are presented below, corresponding to the two priorities focused on in this report. All individual LME Quarterly Reports are also appended to this report. Please note that many of the identified efforts and activities to address one priority will likely impact the second priority as well.

Alliance Behavioral Healthcare

1. Efforts to reduce the need for acute care inpatient admissions for persons with primary diagnoses of MH/DD/SA:
    a. Implement a Community Paramedic Program in Durham and Wake counties to increase diversions from the EDs; determine if model can be used in other two counties;
    b. Expand Critical Incident Training modules that address ED diversion strategies;
    c. Increase CIT trainings in all four counties;
    d. Care coordination for 30-day readmissions; identify and address barriers & challenges; and
    e. Create action plans based on findings of Quality Management research.

2. Efforts to reduce the number of consumers needing three or more crisis services in a twelve month period:
    a. Co-locate Care Coordinators in EDs to provide follow-up to high utilizers;
    b. Utilize CCNC's daily, real time alerts system to notify Care Coordinators of persons admitted to EDs;
    c. Interdisciplinary teams use critical case conferences;
    d. Care coordinators update high risk/high cost crisis plans;
    e. Develop Walk-In assessment center in Cumberland county;
    f. Identify barriers to access to FBC services;
    g. MCM teams collaborate in 4 counties for quicker response;
    h. Education and training to providers to increase the use of first responders; and
    i. Create action plans based on findings of Quality Management research.

Cardinal Innovations Healthcare Solutions

1. Efforts to reduce the need for acute care inpatient admissions for persons with primary diagnoses of MH/DD/SA:
    a. Consumer/provider education on service array & less restrictive interventions;
    b. Provider compliance re. crisis plans & first responders;
    c. Improve engagement in Home and Community Based Services;
    d. Dedicated ED staff who divert from inpatient care;
    e. Review daily ED admissions;
    f. Follow-up for hospital discharges into outpatient;
    g. Expedite authorization for post-ED discharges into step-down; and
    h. Educate/review expected referral responses by providers.

2. Efforts to reduce the number of consumers needing three or more crisis services in a twelve month period:
    a. Care coordination: discharge plans;
    b. Real time hospital census: identify admissions & discharges;
    c. Care coordination: transitional care visits (collaborating with CCNC);
    d. Pharmacist: Medication Reconciliation; contact primary care providers re. discrepancies; ensures integration;
    e. Care coordination desk review of claims, hospital/ED admissions, and Treo list (patient priority list generated by CCNC);
    f. Linkage to and coordination between primary care provider and behavioral health provider;
    g. Coordinate CIT classes;
    h. Conduct CIT twice per year; and
    i. Continue investing resources in FBC services and WICs.

CenterPoint Human Services

1. Efforts to reduce the need for acute care inpatient admissions for persons with primary diagnoses of MH/DD/SA:
    a. Identify reasons for admissions & readmissions to develop interventions;
    b. Develop care coordination protocol;
    c. Peer Support Staff meet with recent hospital readmissions and track reasons shared for readmission;
    d. Trend outcome data to evaluate effectiveness of intervention recommendations & recommend system next steps;

e. Assign two mental health and substance abuse Care Coordinators to focus on and track consumers in ED;
f. Follow-up with consumers who miss hospital discharge appointment and assist in rescheduling while identifying and removing barriers;
g. Meeting with CCNC staff and Hospitals to identify consumers who have had multiple visits to more than one hospital to reduce # of ED visits;
h. Hospital liaisons assisting hospital Social Worker in coordinating care, getting current information on consumers and assuring that discharge plans are adequate;
i. Collaborate with CCNC Integrated Care nurses;
j. Gather input/data to evaluate the need & potential benefits of a FBC including demographics, patient population, short-term hospitalizations & ED visits appropriate for FBC; and
k. Identify potential partners & discuss FBC need, barriers including EMTALA/regulatory concerns, timing & feasibility requirements.

2. Efforts to reduce the number of consumers needing three or more crisis services in a twelve month period:
    a. Train agency staff on how to utilize Care Management Technology (CMT);
    b. Implement CMT into daily workflows;
    c. Use CMT to identify client specific data to check medication compliance and use quality indicators to identify red flags;
    d. Recruit ACT Teams from western, central, & eastern NC; identify participating Teams; and establish a participation agreement with each;
    e. Conduct fidelity review with all Teams to identify areas for training/technical assistance; and
    f. Complete training/technical assistance plans addressing identified needs of each Team.

<u>CoastalCare</u>

1. Efforts to reduce the need for acute care inpatient admissions for persons with primary diagnoses of MH/DD/SA:
    a. Development of community protocols involving police, sheriff, magistrate, Emergency Medical Services, hospitals, primary health, schools;
    b. Creation of 24 hour crisis response centers in close proximity to EDs, etc. to divert utilization of ED;
    c. Education on health promotion of persons with MH/DD/SA to include: nutrition, exercise, reducing stress, regular health screenings, etc.;

d. CoastalCare and providers in the network to educate all persons with MH/DD/SA about emergency services other than use of the ED;
e. Improve marketing and signage for community based crisis services;
f. Community training/certification of providers in the network;
g. Incentivizing practices through contracting/rate setting for recruitment and retention of providers;
h. Link consumers to CCNC; and
i. Partner with CCNC and other service providers in the network to develop protocols with agencies in the community focused on ED diversion.

2. Efforts to reduce the number of consumers needing three or more crisis services in a twelve month period:
    a. Identify evidence based and evidence informed practices and refer people to providers;
    b. Identify evidence based and evidence informed practices and refer people to providers;
    c. Community training/certification of providers in the network; incentivizing practices through contracting/rate setting; recruitment, retention of providers;
    d. Partner with community agencies and recruit more community partners to meet the demand of persons. Direct providers to assist persons with MH/SA/DD to develop a network of natural supports; and
    e. Partner with community agencies as well as providers in the network to create and utilize evidence based early assessment and detection tools and create detailed crisis plans for persons with MH/DD/SA disorders.

<u>East Carolina Behavioral Health</u>

1. Efforts to reduce the need for acute care inpatient admissions for persons with primary diagnoses of MH/DD/SA:
    a. In addition to scheduling the hospital follow-up appointment, schedule a medication management appointment prior to discharge; and
    b. Mine data to determine # of ED admissions associated with current providers, provide technical assistance to providers identified on first responder requirements and mobile crisis. If necessary, sanction providers that fail to fulfill 1st responder responsibilities.

2. Efforts to reduce the number of consumers needing three or more crisis services in a twelve month period:

c. Using CMT Quality Indicators for Medication Adherence with antipsychotics, care coordinators will follow the established workflow and scripts to address barriers and educate individuals served and/or providers; and
d. Care coordinators will assist individuals to identify, educate and link to natural supports or recovery services as a part of ongoing workflows.

Eastpointe

1. Efforts to reduce the need for acute care inpatient admissions for persons with primary diagnoses of MH/DD/SA:
    a. Open meeting forums, information sessions with enrollees, stakeholders and providers;
    b. Collaboration with local law enforcement and magistrates to encourage use of mobile crisis team rather than Involuntarily Commitment.;
    c. Ongoing training and partnership for CIT Officers and use of NC START teams and Respite beds;
    d. Medical Director collaborates with Medical Directors of providers regarding quality of care;
    e. Develop and distribute educational information regarding available mental health, substance abuse, and intellectual/developmental disabilities services and supports as well as Medicaid and state-funded services;
    f. Webinars, brochures & advertisement;
    g. Community Relations Specialists will facilitate Crisis Collaborative forums within the catchment area;
    h. Care Coordinators will support clinical homes in charge of discharge planning for enrollees with an appointment in 7 days; and will follow up with enrollees if appointment is not kept; and
    i. CCNC Coordinators will assist in working collaboratively with Care Coordinators and clinical homes to ensure continuity of care.

2. Efforts to reduce the number of consumers needing three or more crisis services in a twelve month period:
    a. Education regarding available mental health, substance abuse, and intellectual/developmental disabilities services and supports;
    b. Care Coordination assigned to individuals who are considered special populations;
    c. Education using Mental Health First Aid or similar Best Practice Models; and

d. Working with CMT to identify over and under-utilization, patterns of service to establish root causes for readmissions and collaborate with provider and enrollee to reduce another admission;
e. Staff provide follow-up activities to high risk enrollees who do not appear for scheduled appointments; and
f. Monitor first responder activities of providers.

Guilford Center

1. Efforts to reduce the need for acute care inpatient admissions for persons with primary diagnoses of MH/DD/SA:
    a. Provide brochures to the public and provider community that provides information on community based service options for Medicaid and State funded services;
    b. Mobile Crisis will provide brochures and give presentations about Mobile Crisis services and how they can be used to appropriately assist in disposition of persons with MH/SA/DD diagnosis;
    c. LME will meet at a minimum of quarterly with ED physicians to discuss community based service options for those presenting in the ED;
    d. Provide brochures to the public, provider community and local EDs that provide information on Monarch's crisis services; and
    e. LME will obtain a list of consumers in the ED daily. LME will determine if consumers on the list are served by a community provider. If consumer is served by community provider, LME will contact provider to assist with crisis resolution.

2. Efforts to reduce the number of consumers needing three or more crisis services in a twelve month period:
    a. Twice yearly training on developing appropriate crisis plans and
    b. Care coordination supervisor and Quality Management team can review crisis plans of consumers served by care coordination.

MeckLINK Behavioral Healthcare

1. Efforts to reduce the need for acute care inpatient admissions for persons with primary diagnoses of MH/DD/SA:

a. Intensive follow-up by State Hospital liaisons (LME employees) to ensure consumers keep appointments; and
b. Joint visits with hospitalized consumers including LME Hospital Liaisons and Community Providers.

2. Efforts to reduce the number of consumers needing three or more crisis services in a twelve month period:
    a. Aggregate results of First Responder assessment posted on LME's website;
    b. Consumer and Family Advisory Committee chair reports their findings at Info-share;
    c. Technical assistance to providers when needed;
    d. Plans of correction requested according to policy;
    e. Health Call Center (Screening-Triage-Referral function) will monitor utilization of mobile crisis and contact consumers to assist with follow up treatment;
    f. Closely monitor and intervene as needed with consumers utilizing the local hospital for inpatient psychiatric care (three partner contract); and
    g. Increased communication with local CCNC network to improve communication with respect to Medicaid enrollees who are hospitalized for behavioral health issues.

<u>Partners Behavioral Health Management</u>

1. Efforts to reduce the need for acute care inpatient admissions for persons with primary diagnoses of MH/DD/SA:
    a. Utilize the Memphis CIT curriculum, a 40 hour, one week course. Also, initiate "refresher" sessions to ensure fidelity to this Evidenced Based model;
    b. Hold ongoing meetings with trained stakeholders in the crisis services community, which is a part of assuring that the CIT principles are implemented and that there is fidelity to the CIT model; and
    c. Communication reminders will be made through Provider Forums and Partners BHM media communications.

2. Efforts to reduce the number of consumers needing three or more crisis services in a twelve month period:
    a. Assess CUSTOMER SERVICES procedures for First Responder initiation prior to MCM and identify barriers;
    b. Educate the Provider Network regarding First Responder expectations;

c. Complete Geo ACCESS survey to determine availability of Community Based Services (CBS) at all levels of intensity of service need; involve Provider Network in development of CBS where deficits are identified;
d. Develop Training initiatives for CUSTOMER SERVICES and MCM staff to refer to Providers who offer appropriate level of CBS;
e. Communicate expectations to Providers regarding Person Centered Plan development including well-developed crisis plans;
f. Consumers whose first contact with Customer Services (CS) is request for a crisis service will be identified; a sample (25%) will be individually followed to determine if consumer has been linked with appropriate CBS;
g. CS notify Care Coordination unit upon call to CS which indicates a second crisis service is requested;
h. Care Coordination staff utilize a variety of methods and interventions to assist consumers to engage in the appropriate level of clinical supports, including direct contact with consumer, intervention with current Provider, coordination with CCNC care manager, and treatment team meetings; and
i. Care Coordination staff determine if there is an adequate person centered plan to include crisis prevention strategies and natural supports.

<u>Sandhills Center for MH/DD/SAS</u>

1. Efforts to reduce the need for acute care inpatient admissions for persons with primary diagnoses of MH/DD/SA:
    a. Collaborate with/monitor MCM team to link ED admissions to community services;
    b. MCM collaboration with Magistrates, law enforcement, & hospitals to implement Crisis Plans;
    c. Care Coordination for folks with repeated crisis admissions. Link individual to provider and revise service plan;
    d. Collaborate with/monitor MCM team to link ED admissions to community services;
    e. MCM collaboration with Magistrates, law enforcement, & hospitals to implement Crisis Plans;
    f. Care Coordinators meet with ED management to develop strategies to reduce ED admissions & wait times; and
    g. Care Coordination for folks with repeated crisis admissions. Link individual to provider and revise service plan.

2. Efforts to reduce the number of consumers needing three or more crisis services in a twelve month period:

a. Address barriers to accessing services during clinical screenings;
b. Care coordination for highest need/risk: enhance Person Centered Plans (PCPs); and conduct staffing of high risk cases; and
c. Collaboration between Care Coordinators, other LME departments, CCNC, and other stakeholders to develop comprehensive plans for high risk persons.

Smoky Mountain Center

1. Efforts to reduce the need for acute care inpatient admissions for persons with primary diagnoses of MH/DD/SA:
    a. Meet at a minimum monthly with CCNC Networks to staff high risk cases;
    b. Referral to PCP if adverse high risk events (i.e. inpatient admission), if PCP is unknown notify DSS;
    c. Referral to both PCP and CCNC (when in CCNC medical home) for clients meeting high risk;
    d. Identify for CCNC the existing behavioral health provider (BHP). If unassigned, link to BHP;
    e. Upon request provide consultation/cross training for CCNC/primary care provider on behavioral health conditions;
    f. Create a data tracking system to measure outcomes in prevention, early intervention and crisis management;
    g. Develop a marketing plan to enhance community awareness;
    h. Provide community education to build capacity;
    i. Implement Training Library of modules focusing on health promotion, prevention and early intervention, available to community partners;
    j. Target training and technical assistance to support high needs populations: school age children, later life and individually with intellectual/development disabilities;
    k. Increase CIT Classes and Magistrate Training; and
    l. Establish and/or maintain local stakeholder committees to address the need for community based care and to reduce the need for psychiatric inpatient admission and crisis care.

2. Efforts to reduce the number of consumers needing three or more crisis services in a twelve month period:
    a. Development of three or more crisis services within 12 months report;
    b. Weekly review of report by regional Care Coordination Managers with referral to county based Care Coordination staff;
    c. Participation in PCPs for adults or CFTs for children and families;

d. Facilitate linkage to appropriate supports (e.g. Primary Care Physician, Behavioral Health Providers); and
e. The LME-MCO will strengthen WICs and MCM Teams through technical assistance and performance management.

Western Highlands Network (WHN)

1. Efforts to reduce the need for acute care inpatient admissions for persons with primary diagnoses of MH/DD/SA:
    a. Partner with the "Hard to House" sub-committee of the Asheville City/Buncombe County Homeless initiative advisory committee;
    b. WHN will collect relevant data once identified by the committee and
    c. WHN has contracted with Homeward Bound to develop a permanent supported housing program targeting uninsured individuals with no income and are at high risk of hospitalization.

2. Efforts to reduce the number of consumers needing three or more crisis services in a twelve month period:
    a. More effective use and of Crisis Walk-In services;
    b. Move Crisis Walk-In from Federally Qualified Health Clinic (FQHC) to CABHA;
    c. Better access to a continuum with a CABHA;
    d. Increase availability of WIC hours to extend them to 8pm;
    e. Review cases to assess "first responder" response;
    f. Increase use of MCM services by EDs;
    g. More effective use and of WIC services;
    h. Move WIC from FQHC to CABHA;
    i. Better access to a continuum with a CABHA;
    j. Provide and coordinate individual support of Western Highlands Network Care Coordination, Community Care of Western North Carolina, and Case Management for cases identified with two events;
    k. Improve reporting and tracking of homeless individuals;
    l. Investigate expansion of the DIGMA model (Drop-In Group Medical Appointments) could be utilized to reduce costs and absorb the cuts in state funding required with the new budget; and
    m. By embedding a behavioral health professional and a housing specialist in health clinics most frequented by the target population, the system would move toward proactive management of this population. Part of the intake process would include an assessment by the "care manager" for community connections including housing.